

**CARE INDONESIA
FINAL EVALUATION REPORT
VILLAGE MATERNAL AND
CHILD HEALTH
(VMCH) PROJECT**

August 5 - October 30, 1995

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GLOSSARY

Bappedda Tk I :	Regional Development Planning Board, Province level.
Bappedda Tk II:	District Development Planning Board, District level
Bumil :	Ibu hamil (pregnant mother)
Cadre :	Voluntary health worker
CMP :	Community Medicine Post (Pos Obat Desa-POD)
CO/CD :	Community Organization/Community Development
CR :	CARE's chief Representative
Dikes TK I :	Provincial Health Office
Dikes TK II :	District Health Office
FO :	CARE's Field officer
GOI	Government of Indonesia
IPVO	International Private Voluntary Organization
Kanwilkes :	Regional Health Office, a representative of the MOH at the province level.
Lobar :	Lombok Barat (West Lombok district)
Loteng :	Lombok Tengah (Central Lombok district)
Lotim	Lombok Timur (East Lombok district)
MCH :	Mother and Child Health
MOH :	Ministry of Health
NTB :	Nusa Tenggara Barat (West Nusa Tenggara)
ORT :	Oral Rehydration Therapy
PLD :	Petugas Lapangan Desa (field/village supervisor officer)
PM :	CARE's Project Manager
Polindes :	Village maternity post/birthing place
PO :	CARE's Project Officer
Posyandu :	Integrated health and family planning post
Puskesmas :	Government Public Health Center
SDT :	Sub-District Supervision Team for Posyandu (Tim Pokjanal Posyandu Kecamatan)
TBA :	Traditional Birth Attendant (dukun bayi)
TOGA :	Tokoh agama (religious leader)
TOMA :	Tokoh Masyarakat (community leader)
TT :	Tetanus Toxoid Immunization
VMCH :	Village Maternal and Child Health Project
VPHC :	Village Primary Health Care Project II
VST :	Village Supervision Team for Posyandu (Tim Pembina Posyandu)

ACKNOWLEDGMENT

We wish to thank Ms. Ann Thompson, CARE Indonesia Country Director, and **Ms. Catharina Haryono**, the Health Sector Coordinator, for their trust to carry out this final evaluation of the Village Maternal and Child Health project in **Lombok** island, West Nusa **Tenggara** province. We also acknowledge the support of **USAID** in financing the evaluation process. We are grateful to receive strong support from Mr. Muhidin **Azis**, the Head of the Bappeda Dati I, the Heads of Bappeda Dati II, the Heads of Ministry of Health District Offices (**KaDiKes**) in West, Central and East **Lombok**, the participated **Camat**, Puskesmas doctors and Village Head-men (KADES) during the field visit on August 1995.

Additionally, we appreciate as well the cooperation and inputs from CARE staff in **Lombok**, especially Mr. Adji Setioprojo (Chief Representative), Mr. Slamet Riyadi (PM), Mr. Widodo Goentarto (PO), Mr. Ngadiran **Zalil** (PO), and the Field Officers (Mr. Saharudin, **Drs.** Syami Tarik, Hidayatul Fatidiyah, Asdiah Triana, Nur Ikawati, and **Hartati**).

Finally, special thanks are extended to Dr. Liwina Tasman from the MOH-Directorate of Family Health and Ms. Catharina Haryono from CARE for their guidance and insights as members of the final evaluation team during the field-work and report writing.

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Depok, 30 October 1995

EXECUTIVE SUMMARY

The Village Maternal and Child Health (VMCH) project was implemented between October 1992 and August 1995 by CARE, under a jointly-funded CARE and **USAID Child Survival Grant**, in all three districts of **Lombok** island, West **Nusa Tenggara** province, Indonesia. These project sites consisted of 17 villages made up of 124 hamlets with a population of 123,779 people. The community health situation, level of women's education, and government's placement plan for new village midwives were considered in the selection of these **17** villages.

The project accomplishments in comparison to project objectives were evaluated through: (1) several meetings with CARE project officer and field officers in Jakarta and **Lombok** to discuss various aspects of the project including follow-up actions on the recommendations put forth by the midterm evaluation team; (2) comparative analysis between the baseline and final **KPC surveys**, and (3) direct observation by the external evaluators during field evaluation visits to the three districts in Lombok.

To strengthen existing government programs/services through community support rather than develop new ones, the VMCH project strategies included assistance in the health center's role of providing needed support to polindes and village midwives, training the Village posyandu Supervision Teams (**VSTs**) to improve the effectiveness of posyandu, provision of aid in the work of VST in supporting/supervising Posyandu, Community Medicine Posts (**CMs**) and mothers awareness groups (KP-KIA), and provision of support in the training of village midwives in providing maternal care services (polindes). Concurrently all of these activities were conducted at subdistrict level, the village level, and the hamlet level. The proposal stated that CARE would also train, supervise, and facilitate the "managers/leaders" for functioning of these community health institutions.

CARE was partially successful in its objective to promote polindes, although this should not be interpreted as succeeded in increasing the number of deliveries performed in polindes. They were successful, however, in promoting the polindes as a place for ANC, and as a means of allowing midwives to reach and teach the **TBA**s about MCH issues. CARE developed guidelines for community development in terms of the role of polindes, and helped in the facilitation of meetings on how to distribute funds, increase community involvement, and in how to run and develop the polindes. By project end, 6 out of the **14** villages with midwives had developed and were using these guidelines. These 6 also reported regular meetings between midwife and TBA, and had a reporting system for pregnant women in place. The-development of guidelines for community-development of polindes was found as a significant contribution.

A total of **36** Mother Awareness Groups (KP-KIA groups) have been established with a minimum of 15 members each in the **three** districts of Lombok. This is above the **targeted** 34 KP-KIA groups in the **project** proposal and indicated a high level of interest **expressed** by the community in forming these groups. However, observations **during** the visits **revealed** that the groups did not underscore identification of new pregnant and/or lactating mothers with children under two years old as the main objective of group **formation** (as in the original concept). Also, cadres need better initial

training, a proper evaluation of IEC materials' understanding and frequent supervisory visits to determine whether key messages are being presented effectively to the right target audience. Cadres reported members' lack of motivation to attend the regular meetings, resulting sometimes in only 30% to 50% of members present. To increase the number of meeting attendants, KP-KIA meetings would often be conducted together with posyandu (half an hour before posyandu), or a few hours after posyandu. This actually has deviated from the purpose of KP-KIA to allow members to learn more about MCH issues in a relaxed, supportive environment.

There are 33 Community Medicine Posts (**CMPs**) in the area covered by the VMCH project, which is more than the original plan of 30 **CMPs** in the proposal. However, less than 50% of these **CMPs** were found to be running well (showed an average of 30 or more clients who actually sought medicines every month between 1993 and 1995) and making a profit. The &her **CMPs** gained no profit, some were able to restock some of their supplies regularly although they only served an average of only 5 clients per month, but the rest seemed unlikely to survive in the near future and were perceived by health center staff as being "in a dying condition" or "*hidup segan mati tak mau.*" Direct observation discovered that these **CMPs** routinely gave antibiotic tetracycline for treatment of diarrhea, even in young children in which it is contraindicated because of enamel staining of teeth and potential side-effects, plus the potential for bacterial resistance if over-used for the wrong reasons. Often **Oralit** was not given at all. All **CMPs** visited by the evaluation team mentioned having encountered problems with restocking supplies because lack of stocks in the appointed pharmacies, health center or health subcenter.

The formation of Sub-District posyandu supervision Teams (**SDTs**) were anticipated to effectively support at least 17 Village posyandu Supervision Teams (**VSTs**) in this project. Three modules were developed for **SDTs** to train the **VSTs** in capabilities of alleviating the problem of mother and child health care in their area, searching for problem solving alternatives, and implement a work-plan. The modules were developed in collaboration with the government officials and could be used in all subdistricts. In March 1995, to strengthen local institutional development through learning about puskesmas and local institutional development from their colleagues in West Java, CARE had sent 22 people to see two puskesmas, one in Pamanukan, district of Subang and another one in Tanjungsari-Sumedang. This initiative was co-financed by Dati II. West **Lombok**, Central **Lombok** and CARE. The results were said to be very promising. For example, in West **Lombok** they planned to have two model hamlets (April 1996) with a building for integrated servicesconsisted of Polindes, POD and an office for the head of **dusun**. In East Lombok, the Bappeda Dati II initiated development of a model village in **Selaparang** with focus on village midwives, **TBA**s, and **KP-KIA/posyandu** cadres. This could be considered as a very positive outcome of the **project**. Unfortunately, although CARE **Lombok** has evidences that some of the VST members had conducted their tasks. during the evaluation visit some of the posyandu cadres did not even know their VST members' names, and there were even **so-called VST members** who were not even aware they **were** members. Thus, it was **difficult** to draw conclusion **that** the **VSTs** in its present form are a cohesive, well-organized group of people which may sustain.

Rapid Knowledge and Practices Survey for Community Assessment and Action (KPC surveys) using the methodology developed by the Johns Hopkins University PVO Child Survival Support Program were carried out at the beginning of the project (December 1992) and again at the end of the project (July 1995), to see if there has been a significant increase in knowledge, attitudes and practices of various MCH indicators. The results (in Appendix 1) concluded that there was an improvement gained in health knowledge, i.e., the importance of ANC visits, giving colostrum (breastfeeding within 8 hours of delivery), appropriate use of ORS (Oralit), two doses of TT for pregnant women, and more mothers seemed aware of chest indrawing as a danger sign in Acute Lower Respiratory Tract infection. However, interpretation of these results should also consider that other factors may have led to increases in knowledge that are not related to project interventions themselves. The project had not been successful in 'utilizing mother's health cards, increasing contraceptive usage or improving knowledge about appropriate weight gain during pregnancy.

In brief, the VMCH project has certainly taken steps to address some of the important maternal and child health care issues, however, the challenges are many and sustainability of interventions beyond project end have to face lots of shortcomings. Several interrelated lessons can be learnt from CARE's three-year VMCH project. These lessons underscore the complexity of a process designed to assist communities help themselves **in** improving maternal and child **health status**.

To conclude, in a non-traditional bureaucracy way, CARE had played the role of a catalytic intermediary as a PVO working with village-level community organizations for the benefit of poor and under-privileged women and their children. Except for the CMP component, CARE has achieved or surpassed most of its targets/objectives for *process* or *output indicators* and *outcome* or *impact indicators* (see KPC results). Nonetheless, there are concerns with how the project was implemented and the questions for sustainability raised in this final evaluation report. If CARE is able to address these concerns, it is believed that this kind of approach can be used with much success in future maternal child projects.

I. INTRODUCTION

1.1 Background to the evaluation assignment

The purpose of this final evaluation is to assess the effectiveness and the sustainability of the Village Maternal and Child Health (**VMCH**) project implemented between October 1992 and August **1995**. The VMCH project was jointly funded by CARE and a centrally-funded **USAID** Child Survival Grant. The project focused on assisting communities to decrease infant and child mortality and morbidity by enhancing women's participation as planners, implementors and users of government sponsored and community managed health services. Project activities were implemented in all three districts of **Lombok** island, West Nusa Tenggara province, Indonesia. In each district, a subdistrict was chosen based on health status indicators and the presence of a low level of community participation in **health** activities. CARE's project sites consisted of 17 villages made up of 124 hamlets with a population of 123,779 people. The village-sites selection was done in collaboration with the local government and was based on four criteria: 1) community health situation; 2) no other IPVO activities in that subdistrict; 3) level of women's education; and 4) possibility of replication to other areas. These villages were also chosen in accordance with the government's placement plan for new village midwives. The distribution of villages in the three districts were as follows:

- o six villages in Pringgabaya subdistrict in East Lombok,
- o six villages in **Praya Barat** subdistrict in Central **Lombok**, and
- o five villages in Gangga subdistrict in West Lombok.

The final evaluation took place in Jakarta and in Lombok. Nusa Tenggara **Barat** Province from August 17 - August 31 1995. This document is part of the participatory evaluation process **specifically** designed to assess the accomplishments and **sustainability** aspects of the VMCH project in Lombok.

I.2 Ccncl and specific objectives of the final evaluation

The general objectives of **the evaluation** are:

1. To provide expert advice to the final **evaluation** of CARE Indonesia Child Survival Project: Village Maternal and Child Health (VMCH), and
2. To prepare an evaluation report using the **USAID** issued guidelines.

The specific objectives of the evaluation are as follows:

1. To evaluate project accomplishments in comparison to project objectives, including related unintended positive and negative effects;
2. To evaluate project expenditures in comparison to what had been planned in the budget;
3. To summarize lessons learned during the three years of the project; and
4. To evaluate project sustainability as far as community participation and the involvement of the counterpart institutions (Bangda, District and sub-district officials, MOH officials, etc.) is concerned after donor funding ends.
5. To determine the extent to which the midterm evaluation's recommendations had been followed up.

13 Overview of Final Evaluation

The final evaluation involved the following activities:

1. A preparation meeting at CARE Indonesia headquarters in Jakarta attended by the two external evaluators (Meiwita B. Iskandar and Valerie Stott), Catharina **Haryono** - CARE Health Sector, and Slamet Riyadi - the VMCH Project Manager from **Lombok**. The purpose of this meeting was to orient the **external** evaluators to the project and to discuss the schedule for the evaluation. A presentation of some of the key findings of the project was also given. This meeting lasted two days.
2. A review of relevant documents (project proposal, DIP, midterm evaluation, **KPC** survey reports etc.)
3. A meeting in **Lombok** to choose the sites for field visits.
4. Field visits to randomly select project sites **in** all three districts of Lombok. These field **visits** included meetings with **the various government** departments **involved** with the project, including Bappeda I (Provincial Development Planning Board), Bappeda II (District Development Planning Board) and Dikes (district **health office**) as **well as visits to puskesmas** (health centers), polindes, **CMPs** and KP-KIA cadres. The complete list of people contacted can be seen in Appendix - 1.
5. A meeting with all the staff involved with the project in **Lombok** (Project Coordinator, Program Manager (PM), Program Officers (**POs**), and Field

Officers(FOs)) as well as Catharina Haryono from CARE Jakarta. The purpose of this meeting was to allow the external evaluators to ask questions of the entire team on various aspects of the project and especially in relation to the recommendations put forth by the midterm evaluation **team**.

6. Follow-up meetings with CARE's PM and POs in **Lombok** and the Lombok-based external evaluator to clarify questions asked by the evaluators and to discuss preliminary findings with them.
7. A check of the analysis done for the baseline and final KPC surveys and a comparison analysis carried out **between** the two surveys.
8. Meeting in Jakarta between Catharina Haryono (CARE Jakarta) and the Jakarta-based external evaluator to discuss the first draft and information on the budget items.
9. A presentation of the final evaluation team's findings will be given in **Lombok** to all those involved as well as to other interested **IPVOs**.

1.4 Evaluation Team Members

The core evaluation team members consisted of two external evaluators, Dr. Meiwita B. Iskandar and Dr. **Valerie** Stott, one representative from the Ministry of **Health** in Jakarta, Dr. Liwina Tasman. The team leader was Dr. Meiwita B. Iskandar. Dr Meiwita B. Iskandar is currently the director of Center for Health Research, University of Indonesia, with previous experience in the Indonesian Resources Mobilization Study in **Lombok** (1991 and 1993). Dr. Valerie Stott has worked for a MCH project in **Lombok** for over one year allowing for much insight into the practicalities behind the implementation **of such** projects in Lombok. Dr. Liwina Tasman is the Head of Reproductive Health - Section at the Sub-directorate of Family Health, MOH.

II. OVERVIEW OF THE PROJECT

2.1 **Overall** Project Design

The overall project design of the VMCH was based on improving government services for women and children through project training, facilitation and supervision. At the subdistrict level CARE would help train and facilitate the

Sub-District posyandu supervision Teams (SDTs) which in turn would: (1) be responsible for training the Village posyandu Supervision Teams (VSTs) to improve the effectiveness of posyandu; and (2) would facilitate in the health center's role of providing needed support to village midwives. At the village level, CARE would: (1) facilitate in the work of VST in supporting/supervising Posyandu, Community Medicine Posts (CMPs) and mothers awareness groups (KP-KIA); and (2) facilitate in the training of village midwives in providing maternal care services. At the hamlet level CARE **would** train, supervise, and facilitate the managers/leaders for functioning of the community health institutions.

2.2 Project Strategies

Type of interventions. Specific child survival interventions included maternal care, nutrition, oral rehydration therapy (ORT), and immunization. Groups targeted for educational activities included: mothers of children under 2 years of age; pregnant women; mothers attending posyandu; and TBAs.

Phases of activities. The activities were to be phased in as follows: SDT and VST formation and training to start in the second quarter, year 1; village midwife training the third quarter, year 1; formation of women groups the fourth quarter, year 1; and the establishment of **CMPs** in the first quarter of year 2.

There were several reasons behind the design of the project. These were: to strengthen existing government programs/services through community support rather than develop new ones; to **focus** more attention on women; to take a more direct service delivery approach; and to test a model for financial support to posyandu that could be replicated on a wider **scale**.

2.3 Project Components

The VMCH project contained **five** components **for which** activities were monitored through a health information system. These components were:

1. Establishment of a village posyandu supervision **team (VST)** in each village and a **subdistrict posyandu supervision team (SDT)** at subdistrict level, with responsibilities to supervise and monitor posyandu. The establishment of **VSTs** were required by a Pokjanal Decree in April 1990 which placed posyandu supervision as an intersectoral responsibility among the Ministry of Health (MOH), National Family Planning Coordination Board (BKKBN), Family

- Welfare Movement (PI-X), Ministry of Religious Affairs, and the Ministry of Home Affairs - Directorate of **Local** Development;
2. Promotion of Village Maternity **Posts (POLINDES)** including community involvement in Polindes construction and implementation at village level;
 3. Formation of Mothers Awareness Groups (KP-KIA) with responsibilities to attract and educate pregnant and lactating women about MCH issues, and encourage utilization of village midwives or Polindes' **services**. These groups would be established through the existing PKK network to enhance the ability **of** women in planning and implementing community activities. PKK members and village midwives would be trained as facilitators in order to determine the priorities of local women in how to go about achieving greater control over both their own and their families* health;
 4. Establishment of Community Medicine Posts (**CMPs**) equipped with cadres able to diagnose common ailments such as acute respiratory infection (ARI) and diarrhea, prescribe medicines, and conduct referral;
 5. Promotion of integrated health posts (POSYANDU) including efforts to motivate community members to become active posyandu cadres.

In practice, not all hamlets (**dusuns**) in the selected village implemented VMCH project components beyond posyandu. It is important to remember that a village in West Nusa Tenggara province is composed of several hamlets often with a population of over 10,000 inhabitants; this is a larger working area compared, for example, with the village working definition in Java. The smallest village in the project (**Selaparang** in East **Lombok**) has 4 hamlets and a population of 3,000, while the largest village (Gondang in West Lombok) has 15 hamlets with a population of **over 15,000 people**.

2.4 Coals and Objectives

CARE defined four measurable project objectives to be attained by the end **of** the VMCH project:

1. 4,000 pregnant women **would** fully utilize the **services of government** trained village midwives **and** the traditional birth attendants (**TBAs**) they support/supervise;
2. 34 mother awareness groups (KP-KIA) for pregnant women and mothers of children under two years old would be functioning effectively;

3. 30 Community Medicine Posts (CMPs) would be functioning viably making available first line treatment to 120,000 villagers and would identify and refer high-risk children, and generate financial support for 30 posyandus;
4. 3 Subdistrict posyandu Supervision Teams (SDTs) would be functioning and would have effectively trained and supported at least 17 Village posyandu Supervision Teams (VSTs).

Planned inputs included: 468 person months for national technical staff (Project Coordinator, Assistant Project Coordinator, Project Manager, Project Officers, Field Officers); 3 person months for an international technical advisor; 1 person month for CARE's in-house management information system unit; baseline and final KPC surveys; 3 technical assistance visits from CARE USA's Primary Health Unit staff; a **15-day** gender consultancy; materials and equipment including calendars, cadre reference cards, health insurance cards, midwifery kits, TBA kits, lockable medicine cabinets and 4 motorcycles.

Planned outputs included: 17 trained village midwives, 75 trained **TBAs**, 5190 pregnant women receiving **TT**, 34 women's groups established, 85 women's group leaders trained, 30 **CMPs** established, 150 CMP managers trained, 30 SDT members trained, 17 **VSTs** established, 270 VST members trained, 270 posyandu cadres trained, 2 evaluations conducted (baseline and final) and women's groups formation strategy developed.

Expected outcomes included: improved and more fully utilized government services which are responsive to the needs and concerns of women; and a model for financial support to posyandu which would be replicable on a wider scale.

III. METHODOLOGY

3.1 Sample Selection of Villages **Visited**

A two-stage sampling method was **used** to select the villages to be visited by the evaluation team. The first step was to **stratify these** villages into five **categories** ranging from those that **implemented** posyandu and one project component to the ones that activated more than one project components beside posyandu, i.e., **VST/SDT** monitoring, polindes promotion, KP-KIA activities, and CMP. From each category, one village was randomly chosen resulting in the following selected **villages**:

Villages with Project Components Implemented					
Districts	One	Two	Three	Four	Five
W . Lombok			Gondang	Kayangan	
C. Lombok	Mt. Sapah				
E. Lombok		Perigi			Suntelangu

The second step was to list the hamlets (dusun) in each village and visit those which have implemented project components of more than posyandu activity.

Locations visited-by the Final Evaluation Team:

DISTRICTS	HEALTH CENTERS	(Randomly selected) VILLAGES	(Purposively selected) HAMLETS	Project Components
W. Lombok	P. Gangga	1. Kayangan 2. Gondang	1.1. Lokok Rangan 1.2. Dangieng 21. Karang anyar 2.2. Kerurak	KP-KIA, Polindes, Posyandu POD, Posyandu KP-KIA Posyandu, KPKIA POD, Posyandu
C. Lombok	P. Mangkung	3. Mt.Sapah	3.1. Batu Jangkih 3.2. P. Dalam 3.3. Kelanjur II	KP-KIA, Polindes, Posyandu. POD, Posyandu. POD, Posyandu.
E Lombok	P. Labuhan Lombok P. Suwela	4. Perigi 5. Suntelangu	4.1. Bukit Durian 42. Blumbang 5.1. Suntelangu 5.2. Aik Embuk 5.3. Batu Basong I	KP-KIA, Polindes, Posyandu. POD, Posyandu. Polindes, Posyandu. KP-KIA, POD, Posyandu. KP-KIA, POD, Posyandu

3.2. Respondents

In each selected puskesmas, subdistrict, and hamlet, the evaluation team conducted non-structured interviews with targeted informants for 1-15 hours. Altogether, there were eight groups of informants interviewed: (1) the **BAPPEDA** officials at provincial and district levels; (2) the MOH officials (**DIKES**) at provincial and district **levels**; (3) the Heads of Sub-districts (**Camat**), Heads of Villages (**KADES**), and Heads of **Hamlets** (**KADUS**); (4) the health center (puskesmas) doctors; **(5)** the village midwives; (6) the cadres in charge of posyandu, CMP or Mother Awareness Groups (**KP-KIA** women's groups); (7) traditional birth attendants (**TBAs**) involved in posyandu, CMP or **KP-KIA**; and (8) informal community/religious leaders.

3.3. Review of **data** and documents

Data from the field were collected on: observations of puskesmas charts and **records**; Polindes' records and equipment; **CMPs'** records of patient attendance, financial situation and medicine stocks; **KP-KIA** materials and documents, plus an overall assessment of the local environment and situations.

Other data and information obtained came from observations, group **interviews**, and examination of project documents. The latter included:

1. CARE Indonesia VMCH project proposal;
2. VMCH Knowledge, Practice and Coverage (**KPC**) baseline survey report;
3. VMCH Knowledge, Practice and Coverage (**KPC**) final survey report;
4. CARE Indonesia Mid-term Evaluation Report;
5. CARE Indonesia Quarterly report for January - March 1994;
6. CARE Indonesia Child Survival VIII 1993 Annual Report;
7. **Field-work** papers from VMCH project implementation 1995;
8. VMCH **Health** Information System data collected by the two CARE Project Officer (**POs**) and the Field Officers (**FOs**) in each district;
9. Summary of VMCH Project Implementation 1992-1995;
10. Field-notes of evaluation team members (4 persons) during the site visits and briefing with CARE **Lombok** staffs; and
11. Secondary data provided by the visited Bappeda, local puskesmas, subdistrict, **KP-KIA** groups or **CMPs**.

3.4 Data Collection (Fieldwork)

The evaluation team was divided into two groups in order to maximize the number of sites that could be visited within the time available. The teams were **made up** of the external **evaluators**, the representative from the MOH, the **Lombok** Project Coordinator (PC), the PM, two POs, and Catharina **Haryono** (CARE Jakarta).

The fieldwork started on Monday August 21 1995 with visits to Bappeda I (Provincial Development Planning Board) and Dikes Tingkat **II** (District Health Office) of **Lombok Barat**, both of which were located in Mataram. On August 22, 23 and 24 the evaluation teams visited **Lombok** Timur (East Lombok), **Lombok** Tengah (Central Lombok), and **Lombok Barat** (West Lombok) respectively to meet with all the people relevant to the project at district, sub-district, village and hamlet levels. On August **25**, the evaluation team met with project staff at CARE's office in Mataram with the purpose of obtaining additional information **especially** relating to follow-up of the midterm evaluation team's recommendations.

3.5 Data Processing and Analysis

The data from field notes, interviews, discussions, meetings and observations were compiled by the evaluators in Jakarta. Quantitative data were reviewed and cross-checked whenever deemed necessary to do so. The team also used data **compiled** by CARE as part of their routine monitoring system during the course of the project. Using these data, the team was **able** to ascertain whether or not specific targets/objectives had been met. The data were put into a tabular format according to specific objectives, target indicators, accomplishments and explanations for the findings.

IV. PROJECT ACCOMPLISHMENTS

4.1. Comparison between **project accomplishments** and **project objectives**

This section will present data from the **VMCH's** routine monitoring system on project attainments from project **objective #** 1 to project objective # 4. The following (4.2.) section will present additional discussions on considerations and concerns derived from the field-evaluation visits and **interviews with various** informants.

4.1.1. Project Objective # 1

UTILIZATION OF TRAINED MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS (TBAS) BY 4000 PREGNANT WOMEN

Indicators:

Targets	Accomplishments	Explanations
1. 80% of women giving birth in the project's third year (2130) have received complete TT immunization.	79% (2100)	<ul style="list-style-type: none"> - cadres given health card for free medication at health center. - other incentives, i.e., soap, eggs, noodles were also provided. - - increase in number of village midwives in CARE villages.
2 50% of 8000 women (4000) giving birth during the 3 years of the project have 4 prenatal visits to a doctor or midwife.	54% (4356)	<ul style="list-style-type: none"> - involvement of religious leaders in promoting MCH. - increase in the number of village midwives. - promotion of Polindes for ANC
3. 50% of women giving birth during the <i>third year</i> of the project are attended by either the health center midwife, the village midwife or a trained TBA . <i>Data had not been collected for this indicator directly. Instead, KPC final survey data were used.</i>	76%	<ul style="list-style-type: none"> - The proportion of women encouraged to call the village midwives increased, however, the births still occurred at home, attended by a TBA and the village midwife. - Good cooperation between TBA and village midwife.
4. 50% of mothers demonstrate acceptable health knowledge on five areas (defined as a score of 80% on maternal care, nutrition, ORT, ARI and immunization questions).	34% Source: KPC survey.	<ul style="list-style-type: none"> - Not all hamlets had developed project components beyond posyandu

4.12. Project Objective # 2

34 MOTHER AWARENESS GROUPS (*Kelompok Peminat Kesehatan Ibu dan Anak or KP-KIA*) **SUPPORTING PREGNANT WOMEN AND MOTHERS OF CHILDREN UNDER TWO-YEARS OLD ARE EFFECTIVELY FUNCTIONING.**

Indicators

Targets	Accomplishments	Explanations
1. 100% (34) groups are established with minimum of 15 members each (1125 women in total).	36 groups	- 2 extra groups were formed as a result of community's interest.
2. 80% of groups meet at least once a month.	94%	- Develop other social activities such as rice collection (<i>jimpitan</i>), saving & loan scheme (<i>arisan</i>), etc.
3. 75% of the women's group members exclusively breastfeed their youngest child until the age of 4-6 months and give appropriate weaning foods.	66%	- IEC materials given during group meetings include information in the benefits of exclusive breastfeeding. - The provision of examples of supplementary food
4. 75% of women's group members practice oral rehydration therapy if their child had diarrhea in the past two weeks.	70%	- LGG teaspoons were provided - Oralit was not available in all groups
5. 75% of women's group members can identify danger signs of ALRI and sought appropriate treatment when required.	82%	- Target surpassed even though ALRI was not a specific component. Some of the KP-KIA cadres are also ALRI cadres trained by the puskesmas.
6. 75% of women's group participants practice birth spacing after the birth of their last child.	66%	- Target not achieved even though village midwives offered contraceptives

4.13. Project Objective # 3

30 COMMUNITY MEDICINE POSTS (CMPs) ARE FUNCTIONING AS FIRST LINE TREATMENT PROVIDERS TO 120,000 VILLAGERS; IDENTIFYING AND REFERRING HIGH RISK CHILDREN; AND GENERATING FINANCIAL SUPPORT FOR 30 HEALTH POSTS (POSYANDUS)

Indicators:

Targets	Accomplishments	Explanations
1. 80% of CMPs treat an average of 150 individuals monthly. <i>This target was found to be too high at the time of the midterm evaluation and was subsequently decreased to 30 individuals monthly.</i>	30% of CMPs treated an average of 30 individuals monthly.	- multiple problems including: mismanagement, lack of supplies, cost of medications vs. cost of visit to puskesmas
2. 80% CMPs' active cadres identify and refer, through a written system, high risk children to the health center.	37%	- Puskesmas did not provide a special form and many cadres were unused to writing. Therefore most referrals were done verbally.
3. 80% of CMPs restock their supplies as required, and generate at least Rp. 80.000 of profit for posyandu activity.	43%	<ul style="list-style-type: none"> - Most of these CMPs generated only Rp12,000 profit per year (or Rp1000/month) for posyandu activity. - Mismanagement - High cadres turn over rate - Logistic problems and high travel costs.

4.1.4. Project Objective # 4

THREE SUBDISTRICTS POSYANDU SUPERVISION TEAMS (SOTS) ARE FUNCTIONING, EFFECTIVELY TRAIN AND SUPPORT AT LEAST 17 VILLAGE POSYANDU SUPERVISION TEAMS (VSTS). This is a revised objective stated in CARE Child Survival VIII VMCH 1993 Annual Report, p-14.

Indicators

Targets	Accomplishments	Explanations
1. 100% (3) subdistrict teams conduct supervision meetings every two months to at least 12 village teams.	60%	<ul style="list-style-type: none"> - This percentage attainment must be interpreted cautiously because it could not guarantee the quality of supervision given. - 49 SDT members were trained in 1992, but many were changed from the position and became Inactive. New members are recruited if old ones quit
2. 100% (3) subdistrict teams trained at least 180 village team members in posyandu management.	100%	<ul style="list-style-type: none"> - Formal training of 359 VST members in 1992, 529 members in January - March 1994, and another 310 members in July - September 1994 (include refresher training). - Trained team members were not easy to track down whether they were still active or not. - Unavailability of transportation cost was the main problem.

4.2. Evaluation of Project Component Activities.

4.2.1. Promotion of **Polindes**. According to health center doctors in the three districts, the cumulative percentage of births **attended** by trained health personnel (including the village midwives) between **April** and June 1995 was more than during the same period in 1994. However, that did not mean that polindes was used as a birth place. For example, in Sutelangu village, East Lombok, a cumulative **percentage** of 10% of births between April and June 1995 were attended by health

personnel. The village has a **well-built** polindes, with a married **village** midwife at sew-ice all day long. The village midwife said that out of approximately 40 deliveries she attended during a one year period, **only** one occurred at the polindes. In another village in the same district, Perigi village, the polindes had not yet been built. The village midwife lived in the health-subcenter with her husband, a staff of the health subcenter. Both village midwives stated that mothers still preferred to deliver their babies at home and asked **TBA**s to assist them at least for one month after the delivery. A mother and a TBA said (during the field visit) that part of the **TBA** services include washing the dirty clothes, cooking, **looking** after the other children, and bathing the baby. Certainly these services could not be offered by the village midwives.

In Central **Lombok**, the polindes is located next to the village head-man's house, **in** a permanent building also used for posyandu. The married village midwife has to **serve** 12 hamlets as her coverage area. In her nine months work experience, out of over 40 births attended, **only** 5 cases were assisted in the polindes building. This midwife also admitted that she was reluctant to respond immediately to emergency calls because of a tragic experience she had once had. She was five months **pregnant** at the **time** and while answering an "emergency" call, she fell and subsequently suffered a miscarriage. The "emergency" was that the mother had wanted an injection after birth. Later, the evaluation team found out that her area was rough and tough to travel, even with a car, not to mention a motorbike.

In Kayangan village, West Lombok, the married village midwife has served for two years. She travelled around her coverage area using a motorbike. The roads in West **Lombok** are a little bit better than in Central or East **Lombok**. The team had to cancel the visit to her polindes because of a call from a woman with an imminent miscarriage.

Overall, a quick glance at these village midwives in charge of village polindes gave a reflection of mixed feelings consisting of frustration, fatigue and boredom. Nonetheless, although the polindes were not being used very often for actual deliveries, they **were** used for ANC and **also** as a place for midwives and **TBA**s to meet to discuss **MCH** issues. Village midwives were supposed to train **TBA**s in various issues relating to **ANC**, delivery, and post-natal care and this was found to be taking place to some extent. **Apparently, not all TBAs would** attend the educational sessions: the trained **TBA**s would attend on a regular basis but untrained **TBA**s tended not to attend.

Not all villages in the CARE project area had midwives during the project. The GOI however intends to place midwives in all villages eventually. At the end of the project, 14 out of the 17 CARE villages had midwives.

CARE developed guidelines for community development in terms of the role of polindes. For example, they helped in the facilitation of meetings on how to distribute funds, increase community involvement, and in how to run and develop the polindes. By project end, 6 out of the 14 villages with midwives had developed and were using these guidelines. These 6 also reported regular meetings between midwife and TBA, and had a reporting system for pregnant women in place.

In summary, therefore, CARE was partially successful in its objective to promote polindes. They had not succeeded in increasing the number of deliveries performed there due in part to deeply held beliefs and traditions about where births should occur. They were successful, however, in promoting the polindes as a place for ANC, and as a means of allowing midwives to reach and teach the **TBAs** about MCH issues. The development of guidelines for community development of polindes was also a significant contribution..

4.22. Mother Awareness or KP-KIA Groups. CARE reported a total of 36 Mother Awareness Groups (KP-KIA groups) have been established with a minimum of 15 members each in the three districts of Lombok. *This* is above the targeted 34 **KP-KIA** groups in the project proposal and came about out because of interest expressed by the community in forming these groups. Members were supposed to be pregnant and/or lactating mothers with children under two years old, and elderly women (mother-in-law, or grandmother) as suggested in the midterm evaluation. Each group was expected to possess a package of MCH materials consisting of: a flip-chart on MCH selected topics developed by the Ministry of Health and UNICEF in 1994 (entitled “Program Peminat Kesehatan Ibu & Anak”) for the cadre; a dozen or more MCH small books for mothers (memben) on similar issues as explained in the flip-chart; a daily log on KP-KIA memberships and activities for the cadre; one set of mix and match game-cards named as “**Kartu Jodoh**” for testing the extent of mother’s understanding after listening to cadre’s presentation; and a few other books that could be used prior to the distribution of the flip-charts-early in 1995. Each KP-KIA group received an amount of **Rp125,000** from local government (Pemda): 60% of this went towards a health security system for pregnant women and 40% went towards a saving and loan scheme.

In East Lombok, 12 KP-KIA groups *were* established, 7 of which were determined to be well run according to CARE’s Geld officers. They had social

activities such as regular monthly meetings where selected MCH issues were discussed, “*arisan*” or a group saving plan, credit-loan scheme, and rice collection (*jimpitan*). Two KP-KIA groups were visited by the evaluation team, one in dusun Aik Embuk at Suntelangu village, and another one in dusun Karang **Asem** at Perigi village. Both were considered as well-run KP-KIA groups. In Aik Embuk, the **KP-KIA** cadre had been both a posyandu and a CMP cadre since March 1994. She mentioned that she had only received one training session on the MCH educational materials in 1994, given by the subdistrict health center (Puskesmas Suwela) and CARE officers. With 24 members, the initial financial asset of **Rp125,000** had increased to around **Rp150,000** this year. Members paid a registration fee of **Rp500** in the beginning only. Her records showed that 17 out of the 24 members had borrowed money ranging from **Rp10,000** to **Rp50,000** with a maximum payment period of ten months, and interest rate of 10% for each loan. Profit **earned** was used for buying supplementary food and snacks for the monthly regular meetings. The KP-KIA group in dusun Karang **Asem** has 40 members, 21 members had borrowed some loans. The cadre started in October 1994, and stated that she charged a “2% interest” for the loans.. The profit earned was allocated for supplementary food given to mothers during posyandu.

In Batu Jangkih hamlet, Central Lombok, the KP-KIA group has 41 members, but only one pregnant woman. *Added information from CARE Lombok: “If only 1 pregnant woman it is possibly because recruitment is not raking place for new members.” According to Lombok’s external evaluator: CARE Project Coordinator will try to get some figures on composition of other groups to see if recruitment is in fact happening.* Each meeting was. usually attended by 10 women. The beginning asset of **Rp125,000** has turned into a little over **Rp150,000** recently. She never received the MCH flipchart and other materials, therefore she borrows them from other groups when needed for the meetings. CARE had looked into why she did not receive the IEC materials. Apparently they had been given to the **health** center and were supposed to be handed on to her but the materials had “*gone missing*”. CARE therefore suggested that she borrowed the materials from another group.

In **Lokok Rangan** village, West Lombok, the KP-KIA cadre was a young unmarried woman who worked also as a posyandu cadre. She was trained by CARE **once**, in March 1994. **Out of** 24 members, only 3 pregnant women joined the group, the other **were** lactating mothers or non-pregnant, non-lactating mothers. She admitted that the group had very low meeting attendance, thus she arranged the **KP-KIA** meeting half an hour before the posyandu. This groups’s financial assets had been increased from **Rp125,000** to around **Rp200,000**, however, she stated that she never really knew where the money was.

Problems encountered. Cadres mostly performed as the reader of the materials given in the MOH's package on MCH issues. This is a serious problem that can lead to ineffectiveness of the KP-KIA groups. Cadres need better initial training, a proper evaluation of IEC materials' understanding and frequent supervisory visits to determine whether key messages are being presented effectively.

It is possible, however, that other groups were functioning much better and the **evaluation** team happened upon the poorer ones. The problem was discussed with CARE officials and one of the FOs (for West Lombok). According to records kept from their routine monitoring system, only about 25% of the cadres simply read **from** the materials, without having much understanding about their content while the remainder did actively teach what was presented.

Another problem faced by the cadres was lack of motivation to attend the regular meetings, resulting sometimes in only 30% to 50% of members present. To increase the number of meeting attendants, KP-KIA meetings would often be conducted together with posyandu (half an hour before posyandu), or a **few** hours after posyandu. This actually has deviated from the purpose of KP-KIA to allow members to learn more about MCH issues in a relaxed, supportive environment. The company of a child during posyandu weighing, immunization, and food supplementation, etc. would **make it** difficult for mothers to concentrate on the **KP-KIA's** MCH presentation and discussion.

It is important for cadres and other members of the VST to continually recruit new members for the group. As previously mentioned, at least 2 groups were found at the time of the **evaluation** to have only a few pregnant women. This indicates **that** while members may be staying on after delivery, new members are not being recruited. A continual, active process on part of **the** VST in encouraging pregnant women to join the group is necessary in order for **these** groups to be sustained. In spite of these problems, the evaluation team found **the** concept behind the KP-KIA women's groups to be an excellent one. It is suggested that CARE will follow-up on comments discussed later in this report in the section entitled "Lessons Learned". If this is done, the KP-KIA groups is a potential means of improving the health of women and children.

423. Community Medicine Posts. There are 34 **CMPs** in the area covered by the VMCH project, which is more than the original plan of 30 **CMPs** in the proposal. In East **Lombok**, out of 9 **CMPs** implemented by CARE and the communities, only two were found to be running well and making a profit. Bookkeeping records showed an **average** of 30 or more **clients** who actually sought medicines every

month between 1993 and 1995. The other 3 CMPs gained no profit but were able to restock some of their supplies regularly, however they served an average of only 5 clients per month. The other 4, who were still at an initial stage, seemed unlikely to survive in the near future and were perceived by health center staff as being “in a dying condition” or *"hidup segan mati tak mau."*

In East **Lombok** (as well as in the other districts), several problems were uncovered that hindered the success of the CAMP. These were as follows:

1. Training was mentioned as being inadequate especially as it related to the referral process. The Dikes guidelines were thought to be unclear and presented in a manner that was difficult to understand **<ä mamy** of the cadres. This could have serious consequences if a very sick child was not referred to the health center when necessary.
2. The logistics for reordering of supplies were unclear. For example, the cadres would often run out of drugs that were commonly used. This shows that either a simple but well designed method for ordering of supplies had not been implemented in the first place or other factors prevented it from being put into practice. For **example**, perhaps there was not enough money to buy sufficient supplies or not enough money for transportation costs to and from the pharmacy and/or health center.
3. The high turnover of cadres was compounded by informal training of new cadres. In order to achieve sustainability, there must be a system in place to ensure that new cadres are trained properly in the running of the CMPS. This could involve refresher training that would take place every 3-4 months.
4. The people attending the **CMPs** often wanted injections for their various ailments rather than pills, and these of course are not provided at the **CMPs**. The solution to this problem is beyond the scope of the project and will probably require a long time for reeducation of health staff through changes in the medical school curriculum and by government policy before community attitudes can begin to change.

One CMP visited did not have a Puskesmas doctor for over one year and so it was not possible to obtain a prescription for repeat medications. Also, even when prescriptions were available, there was a problem in obtaining the medications from **the** appointed pharmacy in Selong. Apparently this pharmacy would demand extra money if the CMP wanted the **medications** in a **timely** manner. **The** cadres in this community came up with a solution to this problem. Instead of waiting for supplies and paying more money, they went to a non-registered store for their medications. in this way they were able to obtain supplies faster and for a cheaper price and even without a doctor's prescription. The positive aspect of this is that it steers the

community to solve common ailments without relying on the government or CARE. The evidence derived from field visits shows disadvantage of high possibility of irrational use of drugs (see example on tetracycline in Central **Lombok**), the CMP cadres purchased medicines which are not recommended by the government, and interaction between two or three drugs given to community can be harmful if not prescribed properly.

Central **Lombok** built up 17 **CMPs**: seven **CMPs** were able to gain profits, six **CMPs** barely survived with an average of 5 to 10 clients per month, and four **CMPs** were implemented later and considered as still in their early stages of development. Out of the seven profitable **CMPs**, one was visited by the team, located in dusun Klanjur Daye (II). This was the best CMP visited in the three districts during this evaluation field-visit. The CMP was fully utilized by the community, serving an average of over 100 clients every month, with a maximum of 170 clients. People in the area have enough rice stocks for the whole year, however, they do not have enough earnings to buy food and medicines or to go to the health center. Discussions with the members of the community showed that most of the CMP users in the area earned merely an average of **Rp1,000 - Rp2,000** daily. They could not afford the transportation cost of **Rp2,000-Rp2,500** needed to go to the nearest health sub-center in Montong **Sapah** village. A dirt road (no asphalt) was the only access to this dusun and the lack of public transportation made the existence of a CMP in this area greatly appreciated by the community. The CMP is located next to the head of dusun or KADUS' house, and managed by the KADUS and two male cadres, who purchased stocks every two weeks from a Kimia Far-ma pharmacy in **Praya**. From a cash **start-up** of **Rp30,000** from the community and a bag of medicines by **GOI** in 1993, this CMP has cumulated revenues up to **Rp400,000**. Cadres were given T-shirts, and the CMP has a small building with sofas and one bed for those who came late at night and needed a rest.

Another CMP in dusun **Pondok** Dalem gave a different picture with an average -of only 5-10 clients monthly. The cash record showed a balance of **Rp49,000** last December 1994, but most of the money (Rp40,000) had been borrowed by a "warung" for business purposes, leaving the CMP cadre with only **Rp9,000**. Although the cadre stated that the money could be claimed at any time from the "warung" if the CMP needed to restock its supplies, it was apparent that the management of this CMP has deviated from its original objective. There were actually 4 cadres attached to this CMP, each distanced several kilometers from each other. It is possible, therefore, that some records were missing as they may not have been recently recorded in the **CMP's** record books. Other problems at this-particular CMP involved restocking and treatments given. The cadre in the field

visit **interview** stated that he had only restocked his supplies once. This was done at the pharmacy in **Praya** and although he noted no problems in his dealings with them, as it only occurred once over the three years of the project, it is difficult to draw any conclusions about the functioning of the pharmacy.

It was noted that the antibiotic tetracycline was routinely given for treatment of diarrhea, even in young children in which it is contraindicated because of enamel staining of teeth and potential side-effects, plus the potential for bacterial resistance if over-used for the wrong reasons. Often **Oralit** was not given at all. The cadre explained that they had run out and could not afford to restock it especially as it was not thought necessary in the dry season. The cadre explained that most diarrhea cases occurred during the rainy season, however diarrhea still remained one of the most common reported illnesses throughout the year. Another finding at this CMP was- that no patients at all had been seen for a six month period earlier this year. No adequate explanation was given for this although at one point **of** time the key to the medicine cabinet had been lost and no medications could have been given anyway.

In West **Lombok**, out of eight **CMPs**, five were considered as functioning although their performances were still below the achievement of the CMP in Klanjur Daye, Central **Lombok**. The team visited two **CMPs**, an adequately functioning CMP in dusun Dangiing of Kayangan village, and another one which was not functioning well at all in dusun Kerurak of Gondang village. The better CMP in dusun Dangiing was actually new, only started in January 1995, handled by a female cadre who is also practicing as a trained TBA. Her record showed an average of 12-15 clients served each month with a maximum of **28** clients last February 1995. There were no records for August 1995 because she lost the key of the medicine's cupboard that month. The start-up fund from the community was **Rp10,000**. The CMP was now able to have a cash-flow up to **Rp13,500**.

The CMP in dusun Kerurak was implemented in 1991, and gained **lots of** profit in the first two years. From a start-up fund of Rp50.000, the CMP **was able to** accumulate over **Rp110,000**. However, when the new head of dusun (KADUS) took over the **CMP's** management, things rapidly deteriorated. Restocking was always delayed, cadres were inactive, and clients dropped down to zero by August 1995. It was not clearly answered where the community got their medicines, or whether they went *back to the use of traditional medicines*.

Problems Encountered. The original target of an average of 150 individuals served monthly with an average profit of **Rp80,000** for posyandu activity was far too high

for most of the **CMPs**. This was also the conclusion drawn by the midterm evaluation team and as a result, the target was changed to 30 individuals a month. Even this much reduced target was not attainable by most **CMPs**.

Another unattainable objective of the VMCH project was the plan to have a written referral system where cadres referred high **risk** children to the nearest health center or subcenter. This plan was abandoned totally because of limited capabilities in writing and lack of provision of notebooks. In **CMPs** with referral experiences, the cadres said that they went with the patients to the health center or subcenter. -Examination of existing records revealed also that most of the **CMP's** clients were adults, not high-risk children as the original target of this project component.

Mismanagement of CMP was obviously due to four weaknesses: (1) transactions were not documented properly; (2) logistics were not monitored carefully, resulting in lack of well-scheduled purchase of stocks; (3) lack of support and supervision from the KADUS; and (4) a high turn-over of CMP cadres in some dusuns made it difficult to trace who was responsible for the CMP financial problems. All **CMPs** visited by the evaluation team mentioned having encountered problems with restocking supplies because lack of stocks in the appointed pharmacies and/or nearby health **center/subcenter** often resulted in delays of 2 or more weeks. Transportation cost resulting from going back and forth to restock supplies led to less profit.

Relationship with the health **center/subcenter** (Puskesmas or Pustu). The evaluation team concluded that relationships with the health **center/subcenter varied** greatly among these **CMPs**. Whereas some of these **CMPs** built close relationships with the health center's doctor, others did not deal with the doctor at all and only saw one or two members of the other staff, e.g. the nurse, and some only went to health sub-centers with **no** doctor, or worse, purchased stocks from street vendors in the city. Most of all, there was obviously very minimal support from the health center's doctors in **terms** of supervision of the types of medicine delivered by a CMP and as to whether these medicines were prescribed properly to clients. A new health center doctor in East **Lombok** stated that he has not been approached by the CARE field officer about this CMP restocking **business** (he was only two months in this new post). He suspected there were some medicines sold by the health center's staff to the CMP cadres at a price higher than recommended. He suggested that CARE field officers contact health center doctors regularly to communicate problems and needs of **CMPs**, so that health center doctors could assist in assuring the provision of proper medicines for **CMPs**.

Most of the **CMP** cadres interviewed by the evaluation team said that the extent of the health center doctor's role was in writing prescriptions for restocking of supplies. Doctors did not verify whether **CMP's** essential items, e.g. **Oralit**, were available. Moreover, the field visit found that most of the **CMPs** actually did not have **Oralit** in stock. When the evaluation team asked about this, cadres answered that there was no need for **Oralit** until the rainy season comes (end of September) when the epidemic of diarrhea usually occurs. However, when the recording of symptoms in the past three months were observed, almost all **CMPs** sold tetracycline to clients of all ages for the purpose of treating diarrhea. This goes against the policy of the government that specifically states that **CMPs** are not to give antibiotics. There were also more than two types of cough and cold remedies in each **CMP**, white cough syrup (**OBP**), black cough syrup (**OBH**), **glyceryl** guaiacolate, and dextromethorphan. Cadres were not aware of the precautions necessary in prescribing these drugs and were unaware of their side-effects and contraindications. In one of the **CMPs** visited, the antirheumatic drug Piroxicam was highly demanded by the local people despite possible adverse reactions such as gastro-intestinal bleeding and peptic ulceration. Training of **CMP** cadres regarding contraindications, side-effects and specific precautions of the medicines they supply is definitely necessary. The health center doctor can and should play an important role in ensuring the above-mentioned situations do not occur.

Overall, therefore, the **CMPs** have not been a successful component of the **VMCH** project. **CARE** has not been able to ensure adequate attendance in all **CMPs** through promotion as was the original idea, and neither have they been able to facilitate government institutions (*puskesmas*) in guiding these **CMPs** safely and effectively. Nonetheless, in isolated geographical *dusuns*, a **CMP** with the right stock of medicines may play an important role as a first-hand aid to the community.

4.2.4. The function of **SDTs** and **VSTs**. Sub-District **posyandu** supervision Teams (**SDTs**) were anticipated to effectively train and support at least 17 Village **posyandu** Supervision Teams (**VSTs**) in this project. Workshops for **SDTs** were organized in Central **Lombok** in June 1993. to develop a work plan for July to September 1993. In each district, **SDT** members attended a workshop on the background of the **VMCH** project; skills in problem identification, **workplan** development and adult education; and attitudinal issues such as assertiveness, cooperation and awareness of others. These **SDTs** were then supposed to train the **VSTs** using three modules: 1) the responsibilities of **VST** members in alleviating the **problem** of mother and child health care in their area; 2) problem solving **module**; and 3) development of a work-plan module. The modules were developed in collaboration with the government officials and could be used in all subdistricts.

The VST training in West **Lombok** started between April and June 1993 with 181 trainees. At that time (1993), the establishment of **VSTs** was considered urgent in order to reduce the high turn-over rate of posyandu cadres and to motivate women to become active as posyandu cadres. The VMCH field officers were supposed to identify potential VST members in the community. Out of 17 villages, 17 villages had established **VSTs** in the first year of the project. Three hundreds and seventy four members were trained between January and March 1993. Three hundreds and sixty-six **VSTs** members participated in refresher training in July and September 1994.

Based on the midterm review recommendation, in March 1995, CARE had sent 22 people to see two puskesmas in Pamanukan, district of Subang and one puskesmas in Tanjungsari-Sumedang, both in West Java. These individuals were selected among SDT and VST members. The objectives were to strengthen local institutional development through learning about puskesmas and local institutional development from their colleagues in West Java. This initiative was co-financed by Dati II West **Lombok**, Central **Lombok** and CARE. This activity took 10 days and participants consisted of **KaBid SosBud** Bappeda Dati II, **Camat**, Sie KIA West and Central **Lombok** districts, district level PKK leaders from all three districts, and village and health center midwives. The results were very promising, some of these participants developed plans after they returned to their localities. For example, in West **Lombok** they planned to have two model hamlets (April 1996) with a building for integrated services consisted of Polindes, POD and an **office** for the head of dusun. In East **Lombok**, the Bappeda Dati II initiated development of a model village in Selaparang with focus on village midwives, **TBAs**, and **KP-KIA/posyandu** cadres. This is absolutely a very positive outcome of the project.

Although CARE **Lombok** has evidences that some of the **VST** members had conducted their tasks of problem **identification**, solutions or work-plan development, during the evaluation **visit** some of the posyandu cadres did not even know their VST members' names. In Central and West **Lombok**, there were even so-called VST members who were not even aware they were members. The only unfortunate conclusion that can be drawn is that the **VSTs** in its present form are not a cohesive, well-organized group of people. This makes sustainability next to impossible.

43. DISCUSSION OF COMPARISON BETWEEN BASELINE AND FINAL KPC SURVEY DATA

KPC surveys were carried out at the beginning of the project (December 1992) and again at the end of the project (July 1995). The baseline survey data were used mainly to evaluate the situation for future planning and to determine the targets for project objectives. A final KPC survey was done to assess the changes in knowledge and practices concerning MCH near the end of the project. The purpose of comparing data between the baseline and final surveys is to see if there has been a significant increase in knowledge, attitudes and practices of various MCH indicators. It should be remembered, however, that other factors may have led to increases in knowledge that are not related to project interventions themselves. The main focus of this comparison is to see if the objectives stated in the Detailed Implementation Plan (DIP) have been achieved. Not all of the questions asked in the surveys related to specific DIP objectives, but they will be discussed for interest and where appropriate, recommendations will be made for future MCH projects. Overall, there was a significant improvement between the baseline and final surveys on knowledge, attitudes and practices relating to health.

Both surveys used the methodology developed by the Johns Hopkins University PVO Child Survival Support Program: Rapid Knowledge and Practices Survey for Community Assessment and Action. The methodology utilizes the 30 cluster sampling technique to draw the sample size. Approximately 300 mothers with children below the age of 24 months were interviewed during the course of each survey. No problems were reported in the implementation of the **surveys**, and the methodology used was quite appropriate.

A table listing the indicators and the results for the two **surveys** can be found in Appendix 2. Where a statistically significant difference was found (defined as **p<0.05**) the p-value is given; most differences were found to be highly significant with p-values of **p<0.001**.

43.1. Breastfeeding/Nutrition. The project's **strategy** was to facilitate health education at KP-KIA groups and posyandu on infant feeding and weaning foods. The nutritional **health** messages given included: starting breastfeeding within 8 hours of giving birth; breastfeeding frequently to continue milk supply; exclusively **breastfeeding** for 4-6 months; and introducing weaning foods between **4-6months** **that** are rich in vitamin A, protein and calories.

Breastfeeding was found to be universal. The same percentage (95%) of women were breastfeeding in both surveys and all (100%) had breastfed at some point. The percentage of mothers reporting that they breastfed within the first hour had increased from 48% to 56% but this difference was not highly significant ($p=0.05$). The percentage of mothers reporting breastfed between 1 and 8 hours however had more than doubled from 10% to 22% ($p<0.001$). Overall, therefore, significantly more mothers **reported breastfed ‘within 8 hours of delivery at the time of the final survey ($p<0.001$)**. An assumption is that if the baby did not receive breastmilk within 8 hours of delivery, something other than breastmilk would have been given. The WHO message is that mothers should breastfeed exclusively during the first 4 - 6 months of life. The **KPC** survey results showed that although infants were being breastfed earlier, **the percentage of infants aged less than 4 months who were reported being exclusively breastfed had not significantly increased (61% compared to 64%)**.

WHO **recommends** the introduction of supplemental foods between 4 and 6 months. Significantly **more infants between 4 and 6 months were reported receiving solid/semisolid foods (64% in baseline survey and 83% in final survey; $p<0.001$)**. Respondents were asked when they thought weaning foods should be introduced. There was a significant increase in the number of respondents **correctly answering between 4 and 6 months (22% in the baseline survey and 46% in the final survey plus an additional 5% who answered “around 6 months”; $p<0.001$)**. This increase was due, **however**, to fewer respondents answering “over 6 months” and not to a decrease in the number answering before 4 months which had not changed between the two surveys (31% and 30%). This is in **keeping with the number of infants less than 4 months of age who were reported being exclusively breastfed**. As previously mentioned this had not changed between the two **KPC** surveys.

Breastfeeding is recommended up until the age of 2 years. Fewer **children aged between 20 and 24 months were reported breastfeeding at the time of the final survey (a decrease from 100% to 62%; $p<0.001$)**. There was an improvement in knowledge as to which food **supplements were supposed to be given in addition to breastmilk once weaning has begun**. The percentage of mothers knowing that fat should be given had increased from 11% to 27% ($p<0.001$), the percentage knowing that vitamin A should be added had increased from 31% to 64% ($p<0.001$) and the percentage knowing that iron-rich foods should be given had increased from 21% to 34% ($p<0.001$). The improved knowledge about weaning foods appears to have been put into practice in that more mothers were adding high energy items to child’s meals such as **honey/sugar (increase from 21% to 47%;**

$p < 0.001$) and calorie-dense food in the form of fat (24% to 35%; $p < 0.01$). There was no difference in the percentage of mothers adding salt to their **child's** diet (22% in both instances). **This** was not a specific DIP intervention, however, which is unfortunate as iodine deficiency disorders are known to be endemic in **Lombok** (The Indonesian Healthy Start Projects: Goitre Mapping for **Lombok** Island, 1994). It should be noted as well, however, that in **Lombok** not all salt is iodized.

It is encouraging that almost half (48%) of respondents in the final survey could correctly name vitamin A as the vitamin that protects against nightblindness, an **increase** from 30% in the baseline survey ($p < 0.001$). Significantly more mothers could name green vegetables and yellow fruit as being sources of vitamin A ($p < 0.001$) and meat/fish ($p < 0.01$) but in both surveys only 1% of mothers knew that **breastmilk** contained vitamin A and only 7% from the baseline and 5% from the final survey knew that eggs/egg yolk contained vitamin A.

In summary, significant improvements were found in the number of mothers breastfeeding within 8 hours of delivery, number of infants aged 4-6 months being given supplemental foods, knowledge and practice of food supplements and vitamin A knowledge. There had been no significant increase in the number of infants aged less than 4 months who were being exclusively breastfed and there was a decrease in the number of children between 20 and 24 months still receiving breastmilk

43.2. Diarrhea. The objectives stated in the DIP related to oral rehydration therapy (ORT) for children with diarrhea. The actual use of ORT related to women's group members only and not necessarily final survey respondents who were however, to demonstrate acceptable health knowledge on ORT.

The percentage of children experiencing diarrhea in the previous 2 weeks was almost identical in both surveys (35% in baseline and 30% in final surveys). An unexpected finding was that **while 95% of children in the baseline survey who were reported still breastfed received the same or more amount of breastmilk, only 85% of children in the final survey did so ($p < 0.05$)**. There was no difference in the number of children with diarrhea who were reported given the same **or more** amount of fluids **other** than breastmilk. In both **surveys**, most children received at **least** the same amount if not more (81% and 82%). Slightly more children with diarrhea reported received the same or more amount of food in the baseline **survey** (66% versus 51%; $p < 0.05$). Most mothers reported giving ORT but the difference between the two surveys was not significant at the 5% level (52% versus 60%). ORT was reported given almost exclusively in the form of **Oralit** in both surveys.

An encouraging finding was the **decrease** in number of children **being treated with “anti-diarrhea” medicines including antibiotics**. These types of medications are **rarely** indicated for diarrhea and may in fact be dangerous. In the baseline survey, 29% of respondents said they used these compared with only 11% in the final survey ($p<0.001$).

The majority of respondents from both surveys stated they sought help for their child with diarrhea (82% and 83% respectively for baseline and final surveys). **Significantly fewer reported seeking help from *dukuns* (traditional healers) during the final survey** (a huge decrease from 40% to 1%). **Slightly** more respondents said they attended a health center in the final survey (71%) than during the baseline survey (55%) but this was barely significant at the 5% level ($p=0.05$).

As mentioned, fewer respondents in the **final** survey reported giving the same or more amount of fluids to their **child** suffering from diarrhea. It is not surprising, therefore, that when asked what actions should be taken if their **child has diarrhea**, **fewer** respondents from the final survey mentioned giving more liquid ($p=0.02$). It was surprising, however, that only 4% of respondents from the baseline and only 1% of respondents from the final survey mentioned this. **Significantly more respondents mentioned ORS (Oralit) in the final survey however** (54% compared to 33%; $p<0.001$) indicating that ORS promotion during the project was successful.

Far fewer respondents reported not knowing what to do once the child had started to recover from diarrhea (51% in baseline and only 18% in final survey; $p<0.001$). **Significantly more knew to give high calorie food for example** (26% versus only 6% in baseline survey; $p<0.001$). Interestingly, more respondents in the final survey mentioned giving **more** food (28% versus 18%; $p<0.05$) although as mentioned, fewer respondents said they gave the same or more food to their child when he/she had diarrhea.

The project has shown a quite effective promotion in knowledge and appropriate use of ORS (Oralit) from only 33% to 54% in a two and a half year period

433. Acute Respiratory Infection (ARI). The project only focused on Upper Acute Respiratory Infection (ARI) and not Acute Lower Respiratory Infection (ALRI) which requires treatment by a health professional with antibiotics. The solution for ARI was to be done through **CMPs** which provide **simple medicines**. Questions concerning both ARI and ALRI were however asked in both surveys and it is interesting to examine the results.

AR1 was extremely common with 38% of respondents in the baseline and 48% of respondents in the final survey reporting their youngest child as having had an AR1 during the past two weeks ($p>0.05$). ALRI was reported in 24% and 28% of respondents children respectively for the two groups ($p>0.05$). Fewer mothers sought professional help in the latter survey (25% versus 37%; $p>0.05$). More respondents seemed aware of chest indrawing as a danger sign in ALRI during the final survey (20% versus 8%; $p<0.001$); it is possible that this was an indirect benefit achieved as a result of increased exposure to health professionals and possibly due to an heightened awareness of health issues in general.

The project did not have any specific interventions measurable by the KPC surveys

A recommendation mentioned in the baseline report and worth repeating here is that mothers should be educated on **ARI** (e.g. danger signs of ARI). This could be possibly implemented through the KP-IUA women's groups.

43.4. Tetanus Toxoid Immunization. Women's **KP-KIA** groups were used to increase awareness and knowledge about **TT** immunization among pregnant women through the use of IEC materials (e.g. UNICEF flip chart). The project aimed to utilize village midwives and **TBA**s for increasing **TT** coverage and increasing demand as well. Unfortunately records of pregnant women who were able to show Maternal Health Cards (**KMS-BuMil**) were available for only 14 respondents in the final survey (and only 10 persons in the baseline). So, it was not possible to determine from the surveys whether or not this **strategy** had been effective. Data **from** another source (puskesmas and projected number of pregnant women data) did show a high percentage of women receiving **TT** vaccination.

There was a significant increase in knowledge of TT. During the baseline survey **only** 27% of respondents knew that tetanus toxoid (**TT**) protects both mother and child **while** in the final survey 42% of respondents were aware of this ($p<0.001$). As well, 45% of baseline respondents answered that 2 or more doses of **TT** should be given during a woman's pregnancy and this had increased to 70% in **the** final survey ($p<0.001$).

The surveys showed an increasing knowledge of TT from 27% to 42%, of which a significant percentage knew about the need of having a minimum of two doses of TT.

435. Antenatal Care (AK). The project aimed to facilitate coordination among **TBAs** and health center and village midwives in providing ante-natal services/education to pregnant women. Topics relating to ANC, e.g. diet, timing of ANC etc., were topics for women's **KP-KIA** group discussions. Key maternal care messages in the DIP include: the need and timing of 4 ante-natal care examinations by a health professional (non TBA), good nutritional practices for pregnant and lactating women (increased calorie and iron intake), the goal for pregnancy weight gain (10-12 **kgs**), and the means available for modern birth spacing. The measure of project achievement was to use the **MOH's** maternal health card, which could not be attained in both **surveys** (as already mentioned in section 4.3.4).

There was a dramatic improvement in knowledge concerning **when ANC** visits should occur. During the baseline survey only 39% of respondents correctly answered that the first ANC visit should occur during the first trimester. The percentage of **women** correctly answering this question had risen to **63%**, a significant increase ($p<0.001$).

The majority of mothers were not familiar with the required weight gain during pregnancy. Only 6% of mothers in the baseline survey stated that pregnant women should gain 10-12 kgs; the increase to 14% in the final survey was not statistically significant at the 5% level.

The project was to promote but not supply contraceptives. There was no significant increase in the number of women using a family planning method (52% and 55%).

The project's objectives in increasing awareness of ANC visits were met. The project had not been successful in utilizing mother's health cards, increasing contraceptive usage or improving knowledge about appropriate weight gain during pregnancy.

43.6. Health knowledge. In the baseline survey, questions concerning AR1 management, diarrhea management, weaning foods, iron-containing foods and the purpose of 'IT' vaccinations were asked to test the level of knowledge of the respondents. At the time, none could answer **all** five questions, and most knew the **answer to** only one. In the final survey, 9% could answer one question correctly, 26% **could** answer two, 30% could answer three, 28% could answer four and 6% could answer all five questions. With a possible maximum score of 5.0, the mean score obtained by the respondents in the final survey was 3.0; this is an increase from the baseline survey where the mean score was 1.1.

From the scoring averages, it could be concluded there was an improvement gained in health knowledge.

43.7 Relevance to Child Survival Problems

High infant mortality still remains a problem in Lombok. Although the official figures show a decline in the infant mortality rate (IMR), the latest estimate of **93/1000** live births is still higher than the national average. This is also true for the maternal mortality rate (MMR) which is believed to be around 780 deaths per 100,000 live births in **Lombok** compared to the national average of around 450 in **1987 (see Budiarmo's estimate cited in Jus'at, Idrus. Maternal and Child Malnutrition Problems in Indonesia: A Literature Survey. Jakarta: Acad. of Nutrition, 1994:4).**

Most maternal and infant deaths are from preventable or treatable causes. An example of maternal deaths that could possibly be prevented are complications of delivery that might have been anticipated if the woman had attended ANC sessions. Examples of preventable infant deaths include: infants dying from dehydration due to diarrhea which is **completely** preventable by increasing fluids or giving **Oralit** or sugar/salt solutions; neonatal tetanus which still claims the lives of hundreds of babies per year in **Lombok** and which is a completely preventable disease; **ARI** which has become the major killer of infants in 1995 and although difficult to prevent, complications such as pneumonia can be treated if well-functioning health centers are accessible and utilized by the people.

This project has certainly taken steps to address some of the above issues, for example through the promotion of ANC for pregnant women, **Oralit** for children with diarrhea, and through the promotion of posyandu. The challenges are many, however. One challenge **that** might eventually be dealt with through the use of **KP-KIA** women's groups concerns the often fatalistic attitude towards sickness and death. By giving women the skills and tools to take charge of their own and their families' health, this fatalistic attitude may eventually disappear. Another concerns challenging the belief that **"the parents will go straight to heaven if a child dies."** Women's KP-KIA groups may be **the** ideal forum for discussions such as these **problems**, although this kind of change is not likely to **happen** overnight.

V. PROJECT EXPENDITURES

CARE requested funding for a period of thirty six months to achieve the above project's goals, objectives and outputs. A total estimated budget of \$714,144 (\$1.40 per participant per year for the **USAID** contribution) was quite inexpensive in light of the activities proposed to be undertaken (village midwife and TBA training; women's group formation; CMP formation; SDT training and VST promotion). Monitoring and evaluation activities including all surveys cost \$40,785 or 5.7% of the project budget (See additional details in Appendix 3. Budget Pipeline Analysis).

VI. PROJECT SUSTAINABILITY

Sustainability of interventions beyond project end is fundamental to the success of any project. This section looks at the ways in which the VMCH project has attempted to ensure sustainability for each project component. The shortcomings of the project in terms of sustainability will also be discussed.

6.1. Polindes

The MOH is primarily responsible for the implementation and running of the polindes. The project aimed to increase community awareness about the polindes and to collaborate with health center staff on village midwife training. The village midwife would in turn provide health education to the TBA on such things as **ANC**, safe delivery practices and infant feeding. The midwife would also accompany the **TBA** on deliveries.

In 1993 there was a BAPPEDA meeting between community leaders and SDT members in organizing the polindes. Nine midwives were provided with kits to support their work. There has, however, been little involvement since that time. The head of BAPPEDA at the provincial level has promised a small budget to strengthen the interactions among **TBAs**, village midwives and pregnant women, but he stated that the ultimate aim is to have the community, rather than government involvement.

Written guidelines for **implementing** and managing Polindes were developed with CARE's involvement and are in place in 6 villages. It was found that the Polindes are underutilized for actual deliveries although they do provide **ANC** and a place for training sessions between midwife and TBA. While the GO1 will

continue with its plan to place a village midwife in every village, hopes for sustainability mainly lie with community involvement through such means as women groups.

6.2. Mother Awareness **or** KP-KIA Groups

The original proposal called for **close** interaction between the Mothers **Awareness/KP-KIA** Groups and the PKK network. The involvement of the **PKK** at the provincial level remained minimal throughout the project. This may not necessarily be seen as a negative finding from a practical point of view, because there was little to be gained from their involvement, according to CARE field staff. However, **PKK's** involvement at the grassroots level is essential, and it was reported by CARE **Lombok** that to date their involvement has been successful. In West **Lombok**, for example, the **PKK** have allocated a budget of 4.5 million rupiahs for KP-KIA. This kind of involvement will go a long way to achieving sustainability.

The groups need to have interesting and relevant educational materials at hand. There have been problems in the project with the IEC materials either not been available at all or having gone missing somewhere in the distribution process. The evaluation team does not feel that this problem has been adequately addressed either during the project or in terms of future sustainability considerations.

According to CARE **Lombok** staffs, 75% of cadres are presently qualified to give accurate, informative sessions on MCH during the group meetings. **As** mentioned earlier, the other **25%** of cadres simply read the messages from the IEC without understanding and therefore are unlikely to be effective. Although these figures are quite good for now, there is no concrete plan for either refresher training of present cadres or for training of new cadres. Without this, there is a **real** danger of the groups simply dying out. Similarly, there are no specific plans as to how the cadre should go about recruiting new members.

Other problems found during the evaluation that might have a negative impact on sustainability, included the irregular scheduling of meetings at the time of posyandu and a perceived **lack** of training in book-keeping.

Overall, the KP-KIA component of the project has received good responses from the **MOH's** officials in all three districts. According to CARE officers, the provincial government will give **Rp9.5** million rupiahs to the KP-KIA groups. This plan has not yet been put into effect however.

63. Community Medicine Posts

A more direct curative service delivery approach was supposed to be attained through the establishment of self-financing Community Medical Posts (**CMPs**) that would be managed by trained cadres and **would** provide medications for such common ailments as ARI, diarrhea and skin diseases. The proposed plan to have financially self-sustaining **CMPs** reached less than fifty percent success in the past three years. The VMCH project had hoped that revolving drug funds (the **CMPs**) would be one of the most sustainable and acceptable means for communities to help finance their own health services.

The evaluation team suspected that weak points of **CMPs** in **Lombok** are the lack of continuous training to the cadres as managers and poor support from the local puskesmas doctors and village midwives. Relying on technical support from the busy health center doctors was based on the perception that CMP was a new MOH priority and not-CARE's idea. Apparently, it was obvious that doctors did not and could not support **CMPs** after the end of this project. Similarly, it is unlikely that village midwives can back-up **CMPs**. Unlike in Java, a village midwife has to cover a total village population of more than 10,000 people who are often spread over 15 or more dusuns many of which are in isolated geographical spots that are difficult to reach by a bike or motorbike. Without transportation costs, an additional task such as supervising the recording and restocking of **CMPs** was impossible for village midwives or health center doctors.

The idea to generate profits that could be used to help reduce drop-out rates among posyandu cadres was not feasible. Only a few **CMPs could** contribute a small proportion of their profit to pay for such things as supplemental food and vitamins to be distributed freely during posyandu activities. There was no written proof of close-networking **with** PKK, although supposedly, it was to be the organization with the capacity to provide continuous support. KADUS, as the **head** of dusun, plays a prominent role in managing and promoting the utilization of **CMPs**. **CMPs** need to receive strong support from the KADUS and from dedicated cadres in order to achieve success and sustainability.

Sustainability plans in terms of community participation and the community's ability and willingness to continue **implementing** a CMP in their hamlet **are** unclear. CARE field officers and the **VMCI** I project manager had initiated the involvement of religious leaders to promote the use of **CMPs** in order for them to generate sufficient revenues and profits. However, as explained above, there are other external factors such as geographical location, distance from a health

center/subcenter, involvement of health center's doctor, availability of village midwives to supervise, role of KADUS in day-to-day financial and logistics management, and turn over rate of cadres that determine the survival probability of a CMP.

Sustainability in terms of ability and willingness of counterpart institutions to sustain current CMP activities is very unlikely. Discussions with the District Planning Board (Bappeda Dati II), heads of subdistricts (Camat), **health** officials at district level (DIKES Dati II), and the health center's doctors concluded that CMP activity is not of priority at this moment to be continued after CARE's VMCH project ends. In Central and East Lombok, health officials at district level mentioned the possibility of supporting CMP activity through Community Health Insurance Scheme known as "Dana Sehat." In contrast, in West Lombok, a **health official** found that when a community successfully implemented a Dana Sehat scheme the people preferred to go to a health center/subcenter rather than a CMP. When a person pays **Rp500-Rp600** to a health center/subcenter, s/he will receive a three-day **course** of pills (including antibiotics) as well as an injection which is the favored form of medicine for most people. This is much cheaper than buying medicines from a CMP where analgesic or antipyretic drugs cost **Rp75 to Rp100** per tablet.

6.4 **SDTs** and **VSTs**

Through CARE's training modules, the Subdistrict Supervision Team for Posyandu (**SDTs**) and **Village Supervision** Team for Posyandu (**VSTs**) were given descriptions of their **roles and responsibilities for subdistrict supervision and monitoring of posyandu** implementation. CARE had conducted many training at the subdistrict level and expected that **GOI** staff would be responsible for further establishment and support of the **VSTs**. In fact the establishment of **VSTs** was required by a Pokjanal Decree (April 1990), which placed Posyandu **supervision** as an **intersectoral** responsibility among the Ministry of Health (MOH), National Family Planning Coordination Board (BKKBN), Family Welfare Movement (PKK), Ministry of Religious **Affairs**, and the Ministry of Home Affairs - Directorate of Local Development. However, there were no **signs** of **GOI** Initiatives to take over and there were no strong financial and manpower commitments made by any of the above sectors to activate, **SDTs** and **VSTs** with the exception of East Lombok where the Bappeda official stated that a sum of **Rp16.5** million would be proposed to the **1995/96** budget plan for SDT (Pokjanal) transportation costs. SDT members are present in the field however as part of posyandu activities and this is expected to continue.

6.5. Posyandu

Posyandu services for pregnant women included weight gain monitoring, antenatal examinations and the provision of a meal for children to motivate mothers. CARE is not developing a new institution here but only helping improve the **posyandus'** utilization. Although posyandu is considered as an existing sustainable community program, persistent high drop-out rates for cadres occur. It was anticipated that financial support from profits generated by **CMPs** could support and reduce high drop-out rates among posyandu cadres. **As** discussed, this is unlikely to happen, however, the presence of **KP-KIA** groups may help.

VII. FOLLOW-UP of THE MIDTERM RECOMMENDATIONS

7.1. Short-term recommendations

7.1.1. Improving communication, coordination and negotiation with counterparts. The midterm evaluation recommended more involvement with the MOH at the central level considering that health is the key focus of the project. Kanwil's involvement has been minimal since the beginning of the project. According to CARE's representative in **Lombok**, Kanwil was actually involved in site selection and the planning of the activities in 1992, but not in the operational implementation of these activities.

The three Dikes DATI II were chosen as close counterparts to Bappeda. Regular quarterly reports were sent to Bappeda with copies to Dikes Dati II during the past three years, but there was never any feedback from them. When this information was cross-checked with Dikes personnel, Dikes complained that CARE did not involve Dikes in on-going activities and the planning associated with these activities but **only** sent reports after the fact. This has led to a *nun-paying attention* attitude on Dikes part.

KIA materials were distributed by Kanwil in the beginning. Letters from CARE were always addressed to **KaKanWil** but it was not known whether these were forwarded to the appropriate person in charge. The team suggested making contact with **KaBid** PKPP at **KanWil**, rather than Dikes, because at Kanwil office CARE would be dealing with only one person rather than different people at different times which would be the case at Dikes Dati II.

Every six months CARE organized a coordination meeting in collaboration with Bappeda but the person attending the meeting was usually not the Kakanwil or **Kabid** PKPP, but a KaSie-PSM (**community** participation section). CARE has made four formal presentations, two to Bappeda and **two** to Dikes in the past two years. People from Kanwil attended these meetings but CARE received no follow-up actions from them. The evaluation team suggested that CARE contact Sie **KIA** (MCH section) instead of Ka-Sie PSM because Sie-PSM would not have **the** power to propose changes in MCH policy.

Training on health materials was carried out by the puskesmas doctor or village midwife without the supervision of Kanwil and Dikes. During the field visit, the evaluation team found the quality of the training to be inadequate. For example, **KP-KIA** cadres had not been trained properly in how to use the flipchart and game-cards. CARE provided some of the training budget to Dikes but not to Kanwil. Recommended plans in the near future are to involve the appropriate personnel at Kanwil (**KaBid** PKKP). This would be even better if there was an MOU with the MOH as well as with Bappeda.

In conclusion, therefore, the final evaluation team agrees with the midterm team in that involvement of the MOH at the provincial (and national) levels would be appropriate. A- further discussion on how the MOH could have assisted in this project is presented in section 7.1.4. The midterm evaluation also recommended greater involvement with **the** PKK at provincial level. However, the CARE field staff argued that there was little to be gained from province level PKK involvement, the ones that served as being an important informal counterpart was PKK at subdistrict and village levels. VMCH had contacted PKK at these levels especially for **KP-KIA** to use the ***PKK's data wisma*** program in order to identify pregnant women or lactating mothers. So far, it does seem that PKK involvement at the grassroots level is functioning well without involvement from the province level.

7.12. Improving communication and coordination within CARE. CARE personnel for VMCH consisted of one PM, two POs and three FOS. The **PM** held meetings with the POs and FOs every three months. The PM also had meetings with POs **alone every** two months. The POs conducted meetings with FOs once a month to review problems. The FOs revealed that not **all** problems could be solved by the **POs**, especially when the counterpart (village headman) was not supportive of the project. At the time of the midterm review there was only one PO and no PM which created many problems within the organization. However, after the midterm evaluation (October **1994**), a PM was appointed in March 1995 and operational problems were discussed by FOs and POs more frequently. This led to a wider

sharing of information and better coordination within the organization. The FOs were especially pleased with the written job descriptions for each FO and PO that were introduced by the PM.

7.13. Optimizing use of data. Data collected routinely by the project were used mainly for determining target achievements. These data would be examined monthly and if achievements for a particular month were found to be lower than targeted, the Project Officer would discuss operational problems with the FO(s) involved, as recommended in the midterm review. What was not done is to share the problems with other FOs who were in charge for different districts. In terms of sharing information with the MOH counterparts, the VMCH project coordinator stated that although data were reported quarterly to the Bappeda with copies to the MOH office, there has been no written feedback from them so far.

7.1.4. Strengthening the technical capacity of CARE's human resources. The midterm review strongly recommended that both POs and FOs needed further training on basic MCH issues. Unfortunately, this recommendation was not followed up. CARE's representative argued that community development and institutional sustainability were the project's priorities, not MCH itself. Determining the quality of training and supervision were thought to be the health center staffs responsibility and not **CARE's**. Also, the POs felt that the training on **CMPs** and other basic MCH issues in the beginning of the project should have been sufficient. When asked, FOs said that they listened and learned a lot when the village midwives gave health education to cadres and they also read from the reading collections at CARE's office. They felt confident in facing the community, but admitted that they felt inferior in a formal forum attended by doctors.

Discussion with CARE representatives also mentioned the difficulties that would be associated **with** giving formal training. It had been suggested to CARE that the FOs could attend some of the regular classes on MCH **given at** the nursing/midwife schools. The politics behind this suggestion were perceived as being too complex. This **is an** example of how the exclusion of the MOH may have led to this perception. Had **Kanwil been** involved it may have been possible **to arrange** formal training for CARE's staff.

This evaluation team suggested to CARE **Lombok** that formal training with a pre-test and post-test evaluation on **MCH** issues by **an** external trainer would be useful. This could also assist the **management** in evaluating the staffs **capability** and inte-rest, allowing the designation of tasks to those staff who have demonstrated a particular interest or aptitude in specific MCH issues could take place.

7.15. Improvement of the quality of intervention. For Polindes, the midterm recommendation mentioned that the lack of mobility of the village midwives was basically due to inadequate transportation costs. According to CARE officers, they had discussed this problem with local government. In the three subdistricts visited by the evaluation team, all midwives had motorbikes. Some means of monitoring whether or not these motorbikes are put to their intended uses may be useful however as in one village, the husband of the midwife used the motorbike to go to and from his work in a neighboring village.

Extension of **KP-KIA** membership to involve other people **who** have a strong influence on child care such as grandparents, mothers-in-law etc. was another midterm evaluation recommendation that had been implemented and found to be feasible. However, not all hamlets responded rapidly to this idea. A few KP-KIA in each village had invited **TBA**s and mother-in-laws to become members.

The midterm review recommended VST members such as village **midwives** conduct training for CMP cadres in preventive as well as curative health education. This has not been followed up by CARE. This recommendation is probably beyond the scope of this project as many of the cadres are not yet well trained in how to administer medications or **run** the CMP. It would be something to consider for future projects but the evaluation team does not think it is a failure of CARE in not following-up this particular recommendation.

Another type of training strongly recommended by the midterm **reviewers involved** training for posyandu cadres to improve their skills in not only weighing babies and recording their weights, but also in *interpreting* the information and providing appropriate management and follow-up to underweight children or babies who are falling off their growth **curves**. Observations showed that cadres often did not understand the seriousness of continued weight loss and hence did not take appropriate action such as discussing nutrition or referring the child to the health center.. Although CARE had organized a few training sessions after the midterm review, these did not specifically address the problems of monitoring underweight babies and children by posyandu cadres. The recent refresher training were on CMP and KP-KIA, conducted by puskesmas doctors and village midwives. Discussions with CARE officers revealed that they felt their tasks were only to facilitate and not to dictate what was to be trained. Unfortunately, this has neglected the specific recommendation suggested by the midterm reviewers.

The FOs admitted that they never criticized the health center's performance in conducting posyandu. The FOs perceived that all medical personnel were **well-**

trained and everything they did was correct. The evaluation team mentioned that a significant flaw with posyandu was the fact that communication was one-way and there was no opportunity for mothers to ask questions; also the information was often given in a very superficial way or not given at all. CARE's Chief Representative admitted that CARE's FOs did not dare criticize puskesmas staffs in the field in regard to their performance.

CARE has followed up the midterm review recommendation regarding the social-marketing of appropriate, low cost technique for TBA training initiated by Elizabeth Bhoomkar (VSO). They have disseminated this knowledge and given demonstrations of the training kit to other NGOs and divisions of the MOH. This has received a high level of acceptance and positive comments from them.

7.1.6. Documentation and dissemination of practical knowledge and skills in CO/CD in Sasak community. CARE promised to share the experience in implementing VMCH with the local institutions. A few steps that have been taken in doing this were: sharing the IEC materials developed by CARE with other IPVOs; calendars for village supervision teams, free health cards for cadres and their families (**KARTU BEROBAT KADER POSYANDU** gratis), MCH reference cards for cadres (**KARTU PEGANGAN CIDER**); **DANA SEHAT** cards (**JPKM**), etc. CARE also intends to present findings at conferences such as Perinasia.

7.2. Long-term recommendations

CARE **Lombok** has followed-up some of the long-term recommendations mentioned in the midterm review, for example, directing new focuses of interventions at the district level, submitting a draft proposal on Sexual Transmitted **Diseases** to **USAID**, and collaborating with other IPVOs. CARE is Presently working with **PLAN** International in developing a housewife's magazine called **ASYIK**. This magazine would contain a variety of topics relating to MCH. CARE has also developed close relationships with hvo local **NGOs** that have shown an interest in taking over parts of the VMCH project component activities. .

VIII. LESSONS LEARNED

Several interrelated lessons can be learnt from CARE's three-year VMCH project. These lessons underscore the complexity of a process designed to assist communities help themselves in improving maternal and **child** health status. This process involves enhancing women's participation as planners, implementors, and users of public health facilities. Each lesson cannot be looked at in isolation, and have been presented here separately, only for the sake of clarity.

Lesson Number One. The VMCH project focused on women's empowerment by involving them as planners, implementors, and users of public health facilities. The evaluators of this report found that the project had managed well in creating new 'political' space for innovation and boldness of action among the local government non-health officials at province and district levels. For example, in 1993 there was a BAPPEDA meeting between community leaders and SDT members in organizing the polindes, in which the head of BAPPEDA at the provincial level has promised to allocate a small budget to strengthen the interactions among **TBAs**, village midwives and pregnant women, with the ultimate aim to have the community involvement. The conversation with the Head of Provincial BAPPEDA during the evaluative visit reflected his cognizance on VMCH health **related** issues.

Lesson Number Two. The VMCH project was quite innovative in initiating an income generating scheme, skill development program, and a way of improving social awareness to create an informed and self-reliant community. The evaluators found, however, that a more coherent approach was needed to monitor the process. Several problems were uncovered during the final evaluation that had not been addressed by the project members. For example, CMP and KP-KIA cadres needed more training in beekeeping, administration and record keeping. CMP cadres needed more training on common medical conditions, the indications, contra-indications and side-effects **of** the medications they were providing. It is unfortunate that the serious problem of cadres giving antibiotics to children with **diarrhoea** instead of **Oralit** was not identified or dealt with during the project. Some KP-KIA cadres **needed** to have a better understanding of the content of the health education materials, **The** evaluators **believe** that future projects of this kind should strive to find **field officers who** not only **have** an interest in maternal and child **health** issues, but have received some formal training in this area. **This** should lead to a better identification of problems occurring in the field, strong substance monitoring, and more effective ways of dealing with the problems. If **these** issues are taken care adequately during the project, **the chances** for sustainability beyond project end are also increased.

Lesson Number Three. The KP-KIA and CMP project components should start with clearly identifiable target groups. For example, KP-KIA should explicitly state criteria such **as 'fifty percent of the members are pregnant women'** to assure that KP-KIA groups continue to recruit pregnant women in the area. The CMP cadres **should** be reminded of the original concept to serve **as the 'first stop aid' for sick children**, thus the cadres should monitor how many drugs are given out each month to children under-five. **This** will clarify that the expected attainment is 'high utilization' by children, especially children under five years old with Acute Respiratory Infection (ARI) and diarrhea.

Lesson Number Four. There is a conceptual issue lacking in the VMCH project components. Community members per se cannot be expected to automatically understand the concepts behind **the CARE VMCH** interventions. These concepts should be addressed before implementing project activities. The lack of conceptual clarity and proper inbuilt participatory monitoring of these issues led to a diversion of resources meant for the intended target groups.

Lesson Number Five. The credit schemes for KP-KIA group members (i.e., pregnant women and new mothers) should be preceded by basic explanation and transfer of practical organizational skills so that the credit could be optimally used in such that the credit should be used in a way that improves the health of pregnant woman and her family and become an incentive to utilize village midwife and polindes. There should be an effective and continuing way of monitoring the monies and a mechanism for correcting any problems encountered.

Lesson Number Six. All the interrelated health activities of the VMCH project need to be part of a continuing process of institutional building from the village to the provincial government level. Strong political support from a high administrative level is needed to ensure success and sustainability of any kinds of community-based **MCH** services because the users are mothers and children who are generally considered as poor. The project did involve BAPPEDA and has their support but substantial input from **the** MOH at the provincial level (KANWIL) was minima!. Greater involvement **with** the MOH for any future projects of this kind is recommended.

Lesson. **Number Sewn**. It was discovered during **the** project that women in rural **Lombok** still **prefer** to **deliver** their **babies** at **home**. **The** polindes were rarely used for delivery. CARE **may** want to discuss **with** the local government, plans for **a** more advantageous **use** of the polindes. For example, it may be better to use the polindes centers for good ANC and as places for the teaching of **TBAs** by midwives.

Lesson Number Eight. The **CMP** component of the project cannot be considered a success. Multiple problems were uncovered during the evaluation. These include: the distribution of prohibited medications such as antibiotics; the running out of essential supplies, particularly Oralit; selling potentially dangerous medications such as strong cough syrups; mismanagement of funds; losing keys to supply cabinets; high turn-over of cadres; unclear guidelines for referral (according to some cadres); no system of monitoring if appropriate advice was given as to referral or how to take a medication; and a low level of involvement by puskesmas doctors. The **CMPs** are government institutions and it is unlikely that these problems are unique to the CARE villages. The evaluation team recommends that CARE discuss these problems with the appropriate local government officials if **CMP** is still perceived as appropriate primary health care tool in the community based health system.

Lesson Number Nine. CARE had conducted many training at the subdistrict level and expected that **GOI** staff would be responsible for further establishment and support of the **VSTs** since this was mandated in the Pokjanal Decree (April 1990), which placed Posyandu supervision as an intersectoral responsibility among the Ministry of Health (MOH), National Family Planning Coordination Board (BKKBN), Family Welfare Movement (PKK), Ministry of Religious Affairs, and the Ministry of Home Affairs - Directorate of Local Development. However, as in other activities that rely heavily on intersectoral coordination, there is little government support for **VST** and **SDT** in terms of future sustainability.

IX. CONCLUSIONS

To conclude, this evaluation found that CARE had played the role of a catalytic intermediary as a **PVO** working with village-level community organizations for the benefit of poor and under-privileged women and their **children**. Implementation of the **VMCH** project **was** not so much by the traditional bureaucracy as by the women themselves. **The** bureaucracy was expected to provide an additional support system but did not implement the activities.

Except for the **CMP** component, CARE **has achieved** or surpassed most of its targets/objectives for *process* or *output indicators* such as **the** establishment of **36 versus 33 KP-KIA women's** groups and the training of **VST** and **SDT** team **members** in all **three** subdistricts. CARE also **achieved** most of its **targets/objectives** for *outcome* or *impact indicators*, for **example, 54%** versus a target of **50%** of women giving **birth** during **the** **three years** of **the** **VMCH** project had attended four or more prenatal examinations. Again, **the** **CMP** component fell short in this area.

Despite these successes, there are concerns with how the project was **implemented** and the hopes for sustainability. For example, there were imperfections in the field management style of the VMCH project that should become part of the “lessons learned” by CARE team members. Specifically to **Lombok**, continuous dialogues at all levels with the MOH and BAPPEDA officials in West Nusa Tenggara province may overcome some of the problems encountered. The local social infra-structure cannot be separated from the community health situation, the formation of **CMPs** and KP-KIA groups, and the consciousness-raising of both men and women about maternal child **health** issues in order to decrease infant and maternal morbidity and mortality. Much attention to details is necessary to assure **the** sustainability of the CMP and KP-KIA activities. The posyandu and polindes are existing government supported activities that could benefit from strong supervision, however, the SDT and VST **formation** was not effective in fulfilling their supervisory tasks during the three years of the project. The reasons for this should be carefully considered for future projects.

CARE’s VMCH project activities reflected an attempt at mass-mobilization using people’s creativity, local resources and local knowledge as major inputs. If CARE can address some of the concerns raised in this evaluation report, it is believed that this kind of approach can be used with much success in future maternal child projects.

All these reflect an attempt at mass **mobilization**, even in a particular location, using people’s creativity, local resources and local knowledge as major inputs. This is a very cost-effective method.